South Carolina Department of Health and Human Services
Application for the South Carolina Medicaid Program

This application is developed specifically for Aged, Blind, or Disabled Adults.

Note: *You only need to tell us the Social Security Number and answer the questions about being a US Citizen for the people for whom you want full Medicaid benefits. However, if you give us your Social Security Number, even if you are not applying for benefits, it may help us process your application faster. We only use Social Security Numbers to help us verify income.*

- A citizen applying for Medicaid must provide original documents to prove US citizenship and identity
- A non-citizen applying for Medicaid must provide Bureau of Citizenship and Immigration Services (BCIS) documents to support his/her legal entry into the US.
- A non-citizen applying for Emergency Services Only is not required to provide these documents or a Social Security Number.

1. Tell us about yourself. **Date received by DHHS:**

<table>
<tr><td colspan="3">Name (First, Middle Initial, Last):</td><td colspan="3">Social Security Number: (not required for emergency services)</td><td>Date of Birth:</td></tr>
<tr><td colspan="4">Address where you get mail (include apartment number): City: State: Zip Code:</td><td colspan="3">County:</td></tr>
<tr><td colspan="4">Home Address (if not the same as your mailing address): City: State: Zip Code:</td><td colspan="3">Telephone Number:
( )</td></tr>
<tr><td colspan="3">Your Full Name at Birth: This helps us verify citizenship</td><td colspan="2">Your Mother's Full Name at her Birth:</td><td colspan="2">County/State where you were born:</td></tr>
<tr><td>Do you want Medicaid for yourself?
☐ Yes
☐ No</td><td>Sex:
☐ Female
☐ Male</td><td>Marital Status:
☐ Single ☐ Widowed
☐ Married ☐ Separated
☐ Divorced</td><td>Are you currently attending school?
☐ Yes ☐ No
If yes, what grade? ___</td><td>Check all that apply:
☐ US Citizen
☐ Disabled
☐ Pregnant
☐ Emergency Services Only</td><td colspan="2">What language do you use most?
☐ English ☐ Sign Language
☐ Spanish ☐ Vietnamese
☐ Chinese ☐ Other _____
☐ Russian</td></tr>
<tr><td colspan="3">Medicare Number, if applicable:</td><td colspan="4">Race:
☐White ☐African American ☐Mexican ☐Native American/American Indian ☐Cuban
☐Refugee Entrant ☐Puerto Rican ☐Hispanic ☐Asian American/Oriental ☐Other</td></tr>
</table>

If an Authorized Representative is completing this application, please complete the following:

Name: _____ Phone Number:_____

Address: _____ Relationship: _____

_____

2. Tell us about the people who live with you A Social Security Number is not required if applying for Emergency Services Only.

Name: (First, Middle Initial, Last)		**Social Security Number**:		**Full Name at Birth**:		**Mother's Full Name at her Birth**:
Is this person applying for Medicaid? ☐ Yes ☐ No	**Check all that apply**: ☐ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	**Sex:** ☐ Female ☐ Male **Date of Birth:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	**How is this person related to the person on page 1?** ☐ Child ☐ Spouse ☐ Other: _________	**Currently attending school?** ☐ Yes ☐ No If yes, what grade? _________	**County/State where you were born:**
Medicare Number, if applicable:		**Race**: ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other				

Name: (First, Middle Initial, Last)		**Social Security Number**:		**Full Name at Birth**:		**Mother's Full Name at her Birth**:
Is this person applying for Medicaid? ☐ Yes ☐ No	**Check all that apply**: ☐ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	**Sex:** ☐ Female ☐ Male **Date of Birth:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	**How is this person related to the person on page 1?** ☐ Child ☐ Spouse ☐ Other: _________	**Currently attending school?** ☐ Yes ☐ No If yes, what grade? _________	**County/State where you were born:**
Medicare Number, if applicable:		**Race**: ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other				

Name: (First, Middle Initial, Last)		**Social Security Number**:		**Full Name at Birth**:		**Mother's Full Name at her Birth**:
Is this person applying for Medicaid? ☐ Yes ☐ No	**Check all that apply**: ☐ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	**Sex:** ☐ Female ☐ Male **Date of Birth:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	**How is this person related to the person on page 1?** ☐ Child ☐ Spouse ☐ Other: _________	**Currently attending school?** ☐ Yes ☐ No If yes, what grade? _________	**County/State where you were born:**
Medicare Number, if applicable:		**Race**: ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other				

3. Retroactive

Did you or anyone who lives with you receive medical services in the past 3 months?

Who? ____ Which month(s)? ____

In order for us to determine eligibility for these month(s), you are required to provide proof of income and resources for each month listed.

4. Tell us how much income your family has.
Enter GROSS pay before taxes and deductions, not take home pay. Enter zero ("0") if you are not working. **You must send us proof of income for the past 4 weeks**.

Your Income from Employment	**Other Parent's/Spouse's Income from Employment** (*if living in the home)*
Name of person employed _____	Name of person employed _____
Employer's Name _____	Employer's Name _____
Employer's Address _____	Employer's Address _____
_____	_____
Employer's Phone Number (including area code) _____	Employer's Phone Number (including area code) _____
Gross amount earned per pay period before taxes? $_____	Gross amount earned per pay period before taxes? $_____
How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly	How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
Still employed? ☐ Yes ☐ No If no, where did you work last?	*Still employed? ☐ Yes ☐ No If no, where did you work last?*
_____	_____
When did you stop working there? _____	When did you stop working there? _____

Is anyone self-employed? ☐ Yes ☐ No If yes, please name Self-Employment Business and/or Partnership _____

_____

You must send copies of all the most recently filed Federal income tax forms with all schedules.

Other Income	**Amount**	**Which family member gets this income?**	**How often is this income received?**
Child Support	$		
Alimony	$		
Social Security Income	$		
Unemployment Benefits	$		
Veterans Benefits	$		
Workers Compensation/Long Term or Short Term Disability	$		
Money from Friends/Relatives	$		
Retirement/Pensions/Annuities	$		
Other Income (*Please Explain)*	$		

5. If your family does not have any source of income, explain in the space below how your household bills are being paid.

_____

_____

6. Does anyone in your family own the following? You must send proof of Assets/Resources with this application.

Asset/Resource	Yes	No	Company name, address, and phone #; Account/Policy number; and/or Description	Who does it belong to?	What is the value?	How much is owed?
Cash on Hand					$	
Checking Account(s)					$	
Savings Account(s)					$	
Certificate(s) of Deposit					$	
Annuities/Trusts/Stocks/ Bonds					$	
Home Property (location/description)					$	$
Other Property (location/description)					$	$
Life/Burial insurance					$	$
Burial Contracts					$	$
Burial Plots					$	$
Vehicles (make, model, year)					$	$
Retirement Account					$	$
Other (please be specific)					$	$

7. Do you pay someone to take care of your child(ren) under 12 and/or a dependent adult while you work or attend school?

☐ Yes ☐ No _____ Number of children under age 12 and/or dependent adults for whom you pay for care. **You must provide proof of this payment.**

8. Tell us about any health or medical insurance covering anyone for whom you are applying. Please send us a copy of the card(s), front and back. Include Medicaid in another state. Even if you already have health insurance, you can still qualify for Medicaid.

Insurance Company	Policy Number	Policyholder's Name	Policyholder's ID	Persons Covered	What type of coverage is this?

IMPORTANT

Check below to tell us what you attached.

- **Sending this information in with the application will help us to process your application faster.**
- **You must read and sign this form on the last page to complete your application.**

☐ Proof Of Income

☐ Copies of pay stubs for the **last 4 weeks for any adult person listed**; *or* a letter from employer that shows last 4 weeks of GROSS pay.

☐ A copy of the letter telling the gross amount of any benefits received (Social Security, Unemployment, VA, Workers' Compensation, etc.)

☐ Proof of all other income for the last 4 weeks, including child support.

NOTE: You may be required to apply for additional potential benefits, such as unemployment or Social Security Benefits.

☐ Proof of Assets/Resources listed in application.

☐ Proof of income/resources for the past 3 months if you have received medical services.

☐ Most recent income tax forms including all schedules, if you are self employed.

☐ Proof of due date from doctor, nurse, or Health Department for each pregnant woman.

☐ Verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.)

☐ Bureau of Citizenship and Immigration Services (BCIS) documents for each non-citizen applying for full Medicaid. Does not apply to Emergency Services Only.

☐ Original Documents of citizenship and identity for each US citizen applying for Medicaid. (If you have provided this information before, you do not have to provide it again.)

Other documents can be used to provide proof. If you are not sure what to send, call our toll-free line at 1-888-549-0820 for help.

The South Carolina Department of Social Services' Child Support Enforcement Division (CSED) provides services to establish paternity and child support, modify child support orders, and enforce support orders. Services are available to Medicaid beneficiaries without charge. I understand that if I check "no" and ask for child support services later, I will have to pay a $25 fee. I want to voluntarily apply for these services: ☐ Yes ☐ No

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Healthy Connections Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).
    a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.
    b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).
    c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.
    d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.
3. I know that my Social Security Number, which I am required to provide, under §1137(a) (1) of the Social Security Act [42 U.S.C. 1320b-7(a) (1)], may be used or released in connection with the exceptions in Item 2, above.
4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.
5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.
6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.
7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.
8. I know that I may request a hearing if I believe an error has been made in processing my application.

☐ **I have read the Rights and Responsibilities, or they have been read to me.** *(If possible, both the Applicant and Authorized Representative should sign.)*

Applicant's Signature: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____